		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0010637

Facility Name: LaSalle County Nursing Home

Address: 1380 N. 27th Road (Number) Ottawa (City) 61350 (Zip Code)

County: LaSalle

Telephone Number: 815-433-0476 **Fax #** 815-433-9321

IDPA ID Number: 6903330270001

Date of Initial License for Current Owners: 1945

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership	X	County		
IRS Exemption Code			Corporation		Other		
			"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Elizabeth Ramsey **Telephone Number:** 815-433-0476

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12-01-00 to 11-30-01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Elizabeth Ramsey
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Timothy J. Smith, CPA
(Firm Name & Address) T.J. Smith & Associates, 116 E. Washington St. Ste 1 Morris, IL 60450
(Telephone) 815-942-3306 Fax # 815-942-9430

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	104	Intermediate (ICF)	104	37,960	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	37,960	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	14,775	12,353		27,128	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,775	12,353		27,128	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.46%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES [ ] NO [X]

I. On what date did you start providing long term care at this location? Date started 11-01-65

J. Was the facility purchased or leased after January 1, 1978? YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year? YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: N/A Fiscal Year: 12/1/2000-11/30/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary		3,932		3,932		3,932		3,932			1
2	Food Purchase		534,194		534,194	(19,683)	514,511		514,511			2
3	Housekeeping	108,110	18,632	5,789	132,531		132,531		132,531			3
4	Laundry	37,447	10,615	86,726	134,788		134,788		134,788			4
5	Heat and Other Utilities			106,907	106,907		106,907		106,907			5
6	Maintenance	164,271	11,888	23,095	199,254		199,254	38,678	237,932			6
7	Other (specify):*											7
8	**TOTAL General Services**	309,828	579,261	222,517	1,111,606	(19,683)	1,091,923	38,678	1,130,601			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,094,644	53,911	328,602	1,477,157		1,477,157		1,477,157			10
10a	Therapy											10a
11	Activities	90,580	7,123	1,058	98,761		98,761		98,761			11
12	Social Services	55,102		1,767	56,869		56,869		56,869			12
13	Nurse Aide Training											13
14	Program Transportation		841		841		841		841			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,240,326	61,875	331,427	1,633,628		1,633,628		1,633,628			16
	C. General Administration											
17	Administrative	81,419	1,100		82,519		82,519	23,420	105,939			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			14,182	14,182		14,182		14,182			20
21	Clerical & General Office Expenses	49,492	4,769	4,382	58,643		58,643	27,566	86,209			21
22	Employee Benefits & Payroll Taxes			455,382	455,382	19,683	475,065		475,065			22
23	Inservice Training & Education			3,151	3,151	(2,259)	892		892			23
24	Travel and Seminar					2,259	2,259		2,259			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			29,120	29,120		29,120		29,120			26
27	Other (specify):*											27
28	**TOTAL General Administration**	130,911	5,869	506,217	642,997	19,683	662,680	50,986	713,666			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,681,065	647,005	1,060,161	3,388,231		3,388,231	89,664	3,477,895			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LaSalle County Nursing Home #0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			151,751	151,751		151,751	5,665	157,416			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			151,751	151,751		151,751	5,665	157,416			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			6,827	6,827		6,827		6,827			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,940	56,940		56,940		56,940			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			63,767	63,767		63,767		63,767			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,681,065	647,005	1,275,679	3,603,749		3,603,749	95,329	3,699,078			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	89,664		34
35	Other- Attach Schedule **depr adjustment**	5,665		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 95,329		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 95,329		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

LaSalle County Nursing Home

ID# 0010637

Report Period Beginning: 12-01-00

Ending: 11-30-01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number LaSalle County Nursing Home # 0010637 **Report Period Beginning:** 12-01-00 **Ending:** 11-30-01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	38,678	0	0	0	0	0	0	0	0	0	38,678	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	38,678	0	0	0	0	0	0	0	0	0	38,678	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	23,420	0	0	0	0	0	0	0	0	0	23,420	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	27,566	0	0	0	0	0	0	0	0	0	27,566	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	50,986	0	0	0	0	0	0	0	0	0	50,986	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	89,664	0	0	0	0	0	0	0	0	0	89,664	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LaSalle County Nursing Home # 0010637 **Report Period Beginning:** 12-01-00 **Ending:** 11-30-01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	89,664	0	0	0	0	0	0	0	0	0	89,664	45

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	$	County of LaSalle	N/A	$ 21,143	$ 21,143	1
2	V	6	Maintenance		County of LaSalle	N/A	17,535	17,535	2
3	V	17	Administrative Services		County of LaSalle	N/A	15,273	15,273	3
4	V	17	Administrative Services		County of LaSalle	N/A	3,987	3,987	4
5	V	17	Administrative Services		County of LaSalle	N/A	4,160	4,160	5
6	V	21	Clerical Services		County of LaSalle	N/A	11,124	11,124	6
7	V	21	Clerical Services		County of LaSalle	N/A	16,442	16,442	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 89,664	$ * 89,664	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: County of LaSalle
Street Address: 707 Etna Road
City / State / Zip Code: Ottawa, IL 61350
Phone Number: (815-433-0476
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Maintenance - County Engineer	Days	250		$ 83,900	$ 83,900	63	$ 21,143	1
2		Maintenance - Superintendant	Days	250		58,450	58,450	75	17,535	2
3										3
4		County Board committee exp	Permanent committees	22		168,000	0	2	15,273	4
5		County Annual Audit - all fund	Fund type	37,387,217		33,222	0	4,486,466	3,987	5
6		County Attorney	Days	250		130,000	130,000	8	4,160	6
7										7
8										8
9		County Auditors office	Fund type	27,250,000		92,000	0	3,295,000	11,124	9
10		County Data Processing exp	Days	250		411,061	0	10	16,442	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 976,633	$ 272,350		$ 89,664	25

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LaSalle County Nursing Home COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0010637

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,592 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Grounds	513,000	1960	$ 9,950	1
2					2
3	TOTALS	513,000		$ 9,950	3

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1965	1965	$ 480,000	$	30	$	$	$ 480,000	4
5			1965	1965	280,000		30			280,000	5
6			1967	1967	51,675		30			51,675	6
7			1969	1969	123,087		30			123,087	7
8			1970	1970	164,927		30			164,927	8
	Improvement Type**										
9	Building Improvements			1966	4,643		30			4,643	9
10	Building Improvements			1968	35,441		30			35,441	10
11	Building Improvements			1969	9,575		30			9,575	11
12	Landscaping			1970	12,456		20			12,456	12
13	Garage & Blacktopping			1971	22,125		20			22,125	13
14	Blacktop seal			1972	1,487		20			1,487	14
15	Kitchen fire system			1974	985		25			985	15
16	Fire door & fire detectors & roof section			1975	6,391		30			6,391	16
17	Boiler & roof repairs & fire doors			1976	24,443		20			24,443	17
18	Roof repairs & generator & plumbing repairs			1977	28,326		20			28,326	18
19	Roof repairs & cable installation & painting			1978	25,471		20			25,471	19
20	Roof repairs and painting water tower			1979	40,012		20			40,012	20
21	Shower, mixing valve, roof repair, road asphalt, fence			1980	54,262		20			54,262	21
22	Signs, sewer, retubing boiler			1981	31,671		20	1	1	31,671	22
23	New boiler, air conditioner, windows, door alarm, sprinkler			1982	289,413	14,426	20	14,426		289,413	23
24	Sprinkler system, hydrants, water tank, closet doors, chimney			1983	23,135	692	20	1,156	464	22,904	24
25	Boiler room, roof repairs, paint in A & B wings			1984	17,164		20			17,164	25
26	Sewer repairs, call page system, telephone, curtains			1985	38,629	456	20	456		37,254	26
27	Sewer improvements			1986	182,002	6,067	30	6,067		92,015	27
28	Sewer improvements			1987	62,084	2,069	30	2,069		30,519	28
29	Water tower paint and sidewalks			1989	43,548	125	30	4,230	4,105	1,562	29
30	Generator, fire line, linen cooler, chimney, roof, arch			1990	269,784	13,201	20	13,488	287	145,269	30
31	Painting, carpet, chimney, blacktop, water line, trees			1991	36,959	1,848	20	1,848		23,772	31
32	Asphalt driveway, roof, arch repairs			1992	4,120	207	20	207		1,912	32
33	Building and land improvements			1993	60,542	3,027	20	3,027		25,730	33
34	Building Improvements			1994	104,162	5,208	20	5,208		89,232	34
35	Building Improvements			1994	3,037					3,037	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Window renovation project	1995	$ 293,711	$ 14,686	20	$ 14,686	$	$ 93,142	37
38	Cement pad	1995	2,750	138	20	138		758	38
39	Cement pad	1996	5,330	267	20	267		1,467	39
40	Porch oxygen room	1996	33,252	1,663	20	1,663		4,988	40
41	Door alarms/smoke detector	1996	3,110	311	20	311		1,711	41
42	Fire sprinkler system	1998	169,013	8,451	20	8,451		29,577	42
43	Code alert system	1999	26,004	2,457	20	1,300	(1,157)	7,371	43
44	Water tower	2000	621,990	31,100	20	31,100		62,200	44
45	Building Improvements	2001	22,718	1,137	20	1,137		1,137	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,709,434	$ 107,536		$ 111,236	$ 3,700	$ 2,379,111	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 588,387	$ 39,641	$ 41,606	$ 1,965	5,10,15,20	$ 496,203	71
72	Current Year Purchases	22,868	4,574	4,574		5	4,574	72
73	Fully Depreciated Assets							73
74		(71,052)					(65,518)	74
75	TOTALS	$ 540,203	$ 44,215	$ 46,180	$ 1,965		$ 435,259	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport residents	1988 Ford Van	1992	$ 13,370	$	$	$	5	$ 13,370	76
77										77
78										78
79										79
80	TOTALS			$ 13,370	$	$	$		$ 13,370	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,272,957	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 151,751	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 157,416	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,665	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,827,740	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Painting improvements 1972	$ 11,751	$	$ 11,751	86
87	Improvements G2 1974	4,900		4,900	87
88	Auto 1994	3,600		3,600	88
89					89
90					90
91	TOTALS	$ 20,251	$	$ 20,251	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11-30-01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 633,352	$	1
2	Cash-Patient Deposits	1,688		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	158,745		3
4	Supply Inventory (priced at)	13,922		4
5	Short-Term Investments	319,275		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	52,850		8
9	Other(specify): employee trust acct	11,646		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,191,478	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,950		13
14	Buildings, at Historical Cost	3,709,434		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	573,824		16
17	Accumulated Depreciation (book methods)	(2,847,991)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,445,217	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,636,695	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 121,784	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,688		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,834		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	135,641		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to other funds	75,707		36
37	Employee trust account	11,646		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 393,300	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 393,300	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,243,395	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,636,695	$	48

***(See instructions.)**

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,339,695	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,339,695	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(125,113)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (125,113)	17
	B. Transfers (Itemize):		
18	**A. Additions (deductions):**		18
19	**audit adjust to deferred comp after cost report filed**	10,449	19
20	**prior period correction to retained earnings**	18,364	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 28,813	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,243,395	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,061,270	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,061,270	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,500	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,500	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	42,018	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 42,018	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Property tax revenue	1,351,437	28
28a	Other Income	19,411	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,370,848	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,478,636	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,111,606	31
32	Health Care	1,633,628	32
33	General Administration	642,997	33
	B. Capital Expense		
34	Ownership	151,751	34
	C. Ancillary Expense		
35	Special Cost Centers	6,827	35
36	Provider Participation Fee	56,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,603,749	40
41	**Income before Income Taxes (line 30 minus line 40)****	(125,113)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (125,113)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,816	2,190	$ 40,521	$ 18.50	1
2	Assistant Director of Nursing	1,944	2,160	36,187	16.75	2
3	Registered Nurses	17,057	19,529	316,426	16.20	3
4	Licensed Practical Nurses	12,283	14,083	191,284	13.58	4
5	Nurse Aides & Orderlies	32,872	38,050	362,610	9.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,650	5,823	60,491	10.39	8
9	Activity Director	1,848	2,160	26,644	12.34	9
10	Activity Assistants	6,122	6,917	63,936	9.24	10
11	Social Service Workers	4,212	5,135	55,102	10.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	11,855	14,214	164,271	11.56	17
18	Housekeepers	9,488	11,208	108,110	9.65	18
19	Laundry	2,789	3,612	37,447	10.37	19
20	Administrator	1,928	2,160	48,830	22.61	20
21	Assistant Administrator	1,868	2,160	32,589	15.09	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,548	4,320	49,492	11.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,857	2,112	21,066	9.97	31
32	Other Health Care(specify)					32
33	Other(specify) Unit Attend	6,412	7,255	66,059	9.11	33
34	TOTAL (lines 1 - 33)	122,549	143,088	$ 1,681,065 *	$ 11.75	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	820		39
40	Physical Therapy Consultant	45	2,515		40
41	Occupational Therapy Consultant	61	3,355		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	23	1,125		43
44	Activity Consultant	23	1,058		44
45	Social Service Consultant	37	1,767		45
46	Other(specify)				46
47	Bio Tech Laboratory	49	581		47
48					48
49	TOTAL (lines 35 - 48)	358	$ 11,221		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	57	1,555		51
52	Nurse Aides	17,164	325,643		52
53	TOTAL (lines 50 - 52)	17,221	$ 327,198		53

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Elizabeth Ramsey	Admin	0	$ 48,830
Anne Irwin	Asst. Admin.	0	32,589
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,419

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
N/A		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,000
Unemployment Compensation Insurance	4,512
FICA Taxes	131,054
Employee Health Insurance	173,665
Employee Meals	19,683
Illinois Municipal Retirement Fund (IMRF)*	76,701
Employee Uniform Expense	9,450
TOTAL (agree to Schedule V, line 22, col.8)	$ 475,065

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,905
Health Care Worker Background Check	204
(Indicate # of checks performed 17)	
Notifications	172
County Nursing Home Assoc.	1,040
Various Subs, Fees & Letters	5,861
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,182

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
N/A	
In-State Travel	
Mileage	283
Meals	51
Hotel/Motel Lodging	740
Seminar Expense	1,185
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,259

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LaSalle County Nursing Home # 0010637 Report Period Beginning: 12-01-00 Ending: 11-30-01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LaSalle County Nursing Home # 0010637 **Report Period Beginning:** 12-01-00 **Ending:** 11-30-01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **County Nursing Home Assoc. $1040**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **14,310** Line **4**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **56,940**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **19,683** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **19,683**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **T.J. Smith & Associates, P.C.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **county audit to be finalized this wk**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.